NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization/Division of Epidemiology

Immunization Requirements for School Attendance
Medical Exemption Statement for Children 0-18 Years of Age

NOTE: THIS EXEMPTION FORM APPLIES ONLY TO IMMUNIZATIONS REQUIRED FOR SCHOOL ATTENDANCE

Instructions:

1. Complete information (name, DOB etc.).
2. Indicate which vaccine(s) the medical exemption is referring to.
3. Complete contraindication/precaution information.
4. Complete date exemption ends, if applicable.
5. Complete medical provider information. Retain copy for file. Return original to facility or person requesting form.

1. Patient's Name [redacted]
2. Patient's Date of Birth [redacted]
3. Patient's Address [redacted]
4. Name of Educational Institution Coxsackie/Athens School District

Guidance for medical exemptions for vaccination can be obtained from the contraindications, indications, and precautions described in the vaccine manufacturers' package insert and by the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) available in the Centers for Disease Control and Prevention publication, Guide to Vaccine Contraindications and Precautions. This guide can be found at the following website: **http://www.cdc.gov/vaccines/recs/vac-admin/contraindications.htm.**

Please indicate which vaccine(s) the medical exemption is referring to:

- ☑ Haemophilus Influenzae type b (Hib)
- ☑ Polio (IPV or OPV)
- ☑ Hepatitis B (Hep B)
- ☑ Tetanus, Diphtheria, Pertussis (DTaP, DTP, Tdap)
- ☑ Measles, Mumps, and Rubella (MMR)
- ☑ Varicella (Chickenpox)
- ☑ Pneumococcal Conjugate Vaccine (PCV)
- ☑ Meningococcal Vaccine (MenACWY)

Please describe the patient's contraindication(s)/precaution(s) here: See attached Letter

Date exemption ends (if applicable)
9/14/2022

A New York State licensed physician must complete this medical exemption statement and provide their information below:

Name (print) Peter Forman MD NYS Medical License # [redacted]

Address 1499 New Scotland Rd Slingerlands NY 12159

Telephone 518-320-7517

Signature [signature] Date 8/16/2019.

For Institution Use ONLY: Medical Exemption Status ☐ Accepted ☐ Not Accepted Date: _____

DOH-5077 (6/16)

Delmar Family Medicine
1499 New Scotland Rd
Slingerlands NY 12159
518-320-7517

August 16, 2019

RE: [redacted]
DOB: [redacted]

To Whom It May Concern,

[redacted] is a patient of Delmar Family Medicine. [redacted] has not been vaccinated. He has had multiple issues including multiple food allergies, Gluten Enteropathy, abnormal thyroid function, mitochondrial dysfunction and induced porphyria due to lead and mercury exposure. [redacted] has overcome many issues that have manifested as behavioral issues. He had PANDAs and has overcome this as well. I feel that there is an increased risk of adverse events in [redacted] and at this time feel a medical exemption to immunizations is appropriate at this time.

Please contact me with any questions or concerns. My office number is 518-320-7517.

Sincerely,

Peter Forman, MD